UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 13

ADVOCATE HEALTH AND HOSPITALS CORPORATION D/B/A LUTHERAN GENERAL HOSPITAL[1] Employer and PHYSICIANS FOR RESPONSIBLE NEGOTIATION Petitioner

Case 13-RC-20426

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(*c*) of the National Labor Relations Act, as amended, a hearing was held before a hearing officer of the National Labor Relations Board; hereinafter referred to as the Board.

Pursuant to the provisions of Section 3(*b*) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record[2] in this proceeding, the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.[3]

3. The labor organization(*s*) involved claim(*s*) to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(*c*)(*1*) and Section 2(*6*) and (*7*) of the Act.

5. The following employees of the Employer constitute a unit appropriate for the purpose of collective bargaining within the meaning of Section 9(*b*) of the Act:[4]

All residents, fellows in training, and all other non-supervisory physicians employed by the Employer at its facility currently located at 1775 Dempster St., Park Ridge Illinois, 60068; but excluding all other employees, managers, and supervisors as defined in the Act.

DIRECTION OF ELECTION*

An election by secret ballot shall be conducted by the undersigned among the employees in the unit(*s*) found appropriate at the time and place set forth in the notice of election to be issued subsequently, subject to the Board's Rules and Regulations. Eligible to vote are those in the unit(*s*) who were employed during the payroll period ending immediately preceding the date of this Decision, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible are employees engaged in an economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period and their replacements. Those in the military services of the United States may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the designated payroll period, employees engaged in a strike who have

been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced. Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by Physicians for Responsible Negotiation.

LIST OF VOTERS

In order to insure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses which may be used to communicate with them. ***Excelsior Underwear, Inc.*, 156 NLRB 1236 (1966); *N.L.R.B. v. Wyman-Gordon Company*, 394 U.S. 759 (1969); *North Macon Health Care Facility*, 315 NLRB 359, fn. 17 (1994).** Accordingly, it is hereby directed that within 7 days of the date of this Decision, 2 copies of an election eligibility list, containing the names and addresses of all of the eligible voters, shall be filed by the Employer with the undersigned Regional Director who shall make the list available to all parties to the election. In order to be timely filed, such list must be received in **Suite 800, 200 West Adams Street, Chicago, Illinois 60606** on or before November 14, 2000 . No extension of time to file this list shall be granted except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the requirement here imposed.

RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the **Executive Secretary, Franklin Court Building, 1099-14th Street, N.W., Washington, D.C. 20570.** This request must be received by the Board in Washington by November 21, 2000.

DATED at Chicago, Illinois this 7th day of November, 2000.

/s/Elizabeth Kinney
Regional Director, Region 13

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*/ The National Labor Relations Board provides the following rule with respect to the posting of election notices:

(a) Employers shall post copies of the Board's official Notice of Election in conspicuous places at least 3 full working days prior to 12:01 a.m. of the day of the election. In elections involving mail ballots, the election shall be deemed to have commenced the day the ballots are deposited by the Regional Director in the mail. In all cases, the notices shall remain posted until the end of the election.

(b) The term "working day" shall mean an entire 24-hour period excluding Saturdays, Sundays, and holidays.

(c) A party shall be estopped from objection to nonposting of notices if it is responsible for the nonposting. An employer shall be conclusively deemed to have received copies of the election notice for posting unless it notifies the Regional Director at least 5 working days prior to the commencement of the election that it has not received copies of the election notice.

1/ The names of the parties appear as amended at the hearing.
2/ The arguments advanced by the parties at the hearing and in post-hearing briefs have been carefully considered. On November 2nd, 2000, Loyola University Medical Center, through its attorneys, filed a motion for leave to file a response to the Employer's supplemental post-hearing brief. However, the undersigned has made an independent assessment of the evidence in the record, and is not relying on the portions of the Employer's supplemental brief referenced by Loyola to the extent that they conflict with the underlying record. Accordingly, the motion is denied.
3/ The Employer is a corporation engaged in the operation of an acute care hospital.
4/ The Petitioner seeks to represent a unit of all Residents, Fellows in Training, and all other non-supervisory physicians employed by the Employer at its facility currently located at 1775 Dempster St., Park Ridge Illinois, 60068; but excluding all other employees, managers, and supervisors as defined in the Act.

There were several issues presented at hearing. First, the Employer asserts that the Petitioner is not a labor organization, and that the residents are not employees, but students. It also asserts that if the residents are found to be employees, all Chief Residents except one are supervisors. The Employer also asserts that its affiliated and joint venture residency programs result in joint employer status and, therefore, residents in those programs must be included in the unit. The Employer also asserts that any appropriate unit must also include all non-supervisory Advocate Medical Group doctors, who act as attending physicians in residency programs at the Employer's hospital and work in area clinics. It does so in the context of an argument that it is either a single or joint employer with the Advocate Medical Group. The Employer also argues that nine staff physicians employed by it that do not meet the criteria of supervisor should be in the unit. The Petitioner urges that the unit as petitioned for is appropriate.

Facts

The Petitioner, Physicians for Responsible Negotiation (hereinafter, PRN), came into formal existence with the signing of a constitution and set of by-laws for the organization on November 21, 1999. The origin of the PRN stems from a determination by the American Medical Association (hereinafter, AMA) that such an organization was needed within the medical profession. The AMA provided a loan to the PRN to get the organization started and has advanced further loans at various times. The stated purpose of the PRN is to be a labor organization that will promote the art and science of medicine, the betterment of public health and the integrity of the doctor patient relationship through collective bargaining. A Board Member of the PRN testified at hearing that the fundamental purpose of the PRN is to represent physicians for purposes of collective bargaining. Medical doctors and doctors of osteopathy who are engaged in the practice of medicine, and resident physicians and fellows participating in accredited programs are eligible for membership in the PRN. According to the Petitioner, it has participated in other organizing drives in various cities, and was recently certified by the National Labor Relations Board as the bargaining representative for a group of doctors in Detroit, Michigan. The PRN operates under a national board made up of 9 members, none of whom are employed by the PRN. Locally, the PRN employs three officers; an Executive

Director, Robert Bernat M.D., J.D., a Director of Field Operations, Jill Poznik, and Deb Byrd.

The hospital campus is located in Park Ridge, Illinois, and the Employer's top official is Chief Executive Ken Rojek, who maintains an office in an administrative section of the hospital. The Employer, along with several other hospitals and a practice group in the surrounding geographical area, is an operating division of the Advocate Health and Hospitals Corporation (hereinafter, AHHC). Mr. Rojek reports to Richard Risk, President of the AHHC. The Employer is known as a teaching hospital; it has just over 600 licensed beds.

The employees at issue in this case are all physicians involved in the clinical aspect of the Employer's affairs. The Employer has several clinical residency programs in place at the hospital. The general programs are as follows: Emergency Medicine, which is directed by Jon Olsen, MD; Family Practice, which is directed by Ronald Ferguson, MD; Internal Medicine, which is directed by Marc Fine, MD; Obstetrics / Gynecology, which is directed by James Keller, MD; Pathology, which is directed by Jonas Valaitis, MD; Pediatrics, which is directed by Maureen Quaid, MD; Psychiatry, which is directed by Gustavo Hernandez, MD; and Surgery, which is directed by Jack Saletta, MD. There are also numerous sub-specialties that fall within the general programs. All residency programs are governed by accreditation standards set by the American College of Graduate Medical Education (ACGME). In this regard, the structure and function of the Employer's programs are similar to all accredited residency programs that exist across the nation. The residency programs are funded, for most part, though Medicare. The Employer operates several of its clinical programs as non-affiliated, stand alone programs. These programs are Family Practice, Internal Medicine, Obstetrics and Gynecology, Pediatrics, and Psychiatry.

Residency programs are typically three years in length, with the exception of the Psychiatry and Obstetrics / Gynecology residencies, which consist of four years of training. Persons eligible to be residents are medical school graduates who have passed Parts 1 and 2 of the U.S. medical licensing exam. Typically, the Employer takes applications from graduating medical students each year for their programs, which are examined by department program committees. The Employer then submits a list of ranked applicants for each program to a national matching service for residents. Prospective residents rank various programs and submit their own list to the same service. The service then "matches" residents to particular programs. Individuals qualified to become residents typically apply to specific programs because they wish to become certified in that area of medicine. For example, a resident who has successfully completed the three year rotation in Family Practice receives a certificate of completion from the Employer, and is considered "Board-eligible", e.g., eligible to sit for a written exam in that chosen specialty. The resident, upon passing such an exam, may then hold themselves out as "Board Certified" in that specialty.

All programs utilize a combination of didactic lectures and clinical training. Residents in all programs are trained by, and work under the direction of attending

physicians. Residents perform a variety of medical services, such as varied tasks that arise from direct patient care, work-ups, rounds, and issuing do-not resuscitate orders. In every program, residents have to master certain procedures in order to progress to a level of adequate competency. This is typically tracked by "procedure cards". For every procedure mastered, a resident will have a card signed by an attending or Chief Resident. Cards are submitted to the a program director on a weekly basis, and entered into a computer. Every six months, the residents are given a printout of those procedures for which they are judged competent in. Any procedure that a resident does before they are certified must be directly supervised by a more senior resident or an attending physician. Resident responsibility in respective programs increases with experience. Third and second year residents (or fourth year residents, depending on the program) have greater autonomy and capacity to perform patient care, and help in evaluation of lesser experienced residents. Often, there is no attending physician present when residents are working, though attending physicians are always the physician of record for patients. More senior residents also assist in training; e.g. a third year assists in training second and first year residents, and second year residents assist in training first years (first year residents are also referred to as interns).

After their first year, residents will be eligible to "moonlight", e.g. work at various times as doctors for extra money. The Employer gives preference in "moonlighting" opportunities to residents in its stand alone programs. There are also fellowship opportunities in several of the sub-specialty divisions, such as Cardiology, Gastroenterology, Neonatal-Perinatal, Pediatric Critical Care, Sports Medicine, and Geriatrics. (Fellowships are typically one to three year, focused program opportunities that build knowledge and experience in the particular specialty area.) The parties stipulated that the fellows in the Employer's programs are to be treated identically to the residents in terms of employment status.

There are approximately 170 residents employed in the Employer's stand alone residency programs. Residents in the Employer's stand alone programs apply directly to the Employer for spots in these programs, and have all their terms and conditions of employment set by the Employer. For example, wages, benefits, scheduling, program details, and credential issuance for residents in these programs are all handled solely by the Employer. Residents in these programs are given a stipend from the Employer that increases each year. They are provided with additional benefits such as health insurance, through the Employer. They sign a contract with, and are disciplined and accredited by the Employer as well.

In addition to the stand alone residency programs, the Employer also has several affiliated programs. For example, the Employer has an affiliation agreement with the University of Chicago in Emergency Medicine. The residents in this program apply for positions with, and are selected solely by, the University. They are also accredited by, and have terms and conditions of employment such as wages, benefits, and minimum and maximum hours to be worked, set by the University. Residents in this program have signed an employment agreement with the University of Chicago as well, and are provided workers compensation through the University. Via the affiliation agreement,

residents rotate through the Employer's hospital, usually in four week stints that will typically repeat every three or four months. The Employer reimburses the University of Chicago in a lump sum for an amount proportionate to the time the rotating Residents spend on the Employers campus. The affiliation program is administered primarily by Dr. Howes, the University's Program Director, who was appointed by the Chief of Emergency Medicine at the University. The appointed Program Director oversees the administration of the affiliation program, in consultation with an Employer Program Director that is on-site, who is appointed by the Chairman of the Employer's Emergency Medicine unit, in consultation with the Chief at the University. If disagreement occurs concerning administration of the program, the ultimate authority lies with the Chief at the University of Chicago.

The Employer also has several additional affiliated programs in various sub-specialties. There is an affiliation agreement with the University of Chicago in Neurology, the relevant terms of which are similar to the affiliation agreement between these same parties in Emergency Medicine. The Employer has affiliation agreements with the University of Illinois, which is not an employer subject to the jurisdiction of the Act. In this agreement, various members of the University's staff will spend time at the Employer's site. For example, the University's orthopedic surgery residents will rotate in for a brief period. The University, however, retains all authority in regard to the labor relations of residents that rotate at various times though the Employer's site. This applies with residents who rotate though the Employer's Psychiatry program from the University as well.

There is also an affiliation agreement with Loyola University in Urology. Presence of a Loyola resident via this agreement typically consists of a single resident at any given time, and three total during the course of a year. These residents belong to Loyola's program and the arrangements are similar to those which the University of Chicago has with the Employer. Loyola selects, pays, provides benefits to, and provides accreditation for the residents. The affiliation agreement allows the Employer to take immediate corrective action, such as suspension, if a resident is not performing satisfactorily on Employer's site, but requires that Loyola be informed so that it may take its own appropriate action. Loyola also appoints a program coordinator to act as an administrative liaison between the Employer and the University. The Employer appoints its own liaison as well, but the agreement is explicit in stating that the Employer's liaison has no employment status with the University. The Employer is also asked to evaluate the residents while they are at the hospital and provide this information to Loyola.

There are also, from time to time, additional residents from other hospitals and programs that spend brief periods at the Employer's hospital without the existence of an affiliation agreement. Typically, these residents have taken their own initiative to set up a brief elective rotation at the Employer's site because of some desire to experience a part of the Employer's practice. For example, there have been several residents from Loyola who spent periods of time in the Employer's Pediatric Gastroentology department. There is no regularity to such occurrences and residents who set up elective arrangements with the Employer do not do so under any affiliation agreements. These residents are still

employed by, paid by, and have benefits from, and return to the hospital or program they came from.

In addition to the affiliated programs discussed above, the Employer also has joint-venture agreements by which residents rotate through its hospital. One such agreement is in the Pathology program. The Employer belongs to a joint venture with two area hospitals, called the Metropolitan Group (hereinafter, MGH). The program is also associated with the University of Illinois. It functions through a governing board, made up of representatives from each participating hospital who have an equal vote, and a member from the University of Illinois who sits on the board but does not have a vote. The board is responsible for setting the policies, including resident employment matters, of the program though majority vote. The program is administered by a Pathology Program Director. There is also a designated "administrative hospital", Illinois Masonic, which provides certification, payment, benefits and other terms of employment to residents participating in the program. Residents also sign a contract with Illinois Masonic for employment.

Each member of the MGH contributes to the residency program budget, in proportion to the number of residents at its site. For example, the Employer contributes for eight residents, Illinois Masonic for ten. (The Employer will always have eight residents on site, though the individual makeup of the eight is continually shifting as residents rotate in and out.) The Pathology Program Director is also located at Illinois Masonic and is primarily responsible for the scheduling of resident rotation.

The residents in the Pathology program rotate through each the three participating hospitals every year in the course of their residencies. There are also four other area hospitals where residents will spend a brief period of time during their four years in the program, but time is mainly spent at the participant sites. Residents will stay at the Employer's facility anywhere from one to four months at a time, depending on where they are in the program and how they are scheduled. During the span of the four year program, the Employer estimated that a resident may spend roughly 13 months total on its site. While at the Employer's site, residents typically work in a lab on the 5th floor of the main hospital. While on the Employer's site, the residents are evaluated by the Pathologists working at the Employer's site. These evaluations are sent to the Program Director at Illinois Masonic.

The Employer has another joint-venture agreement with the MGH in Surgery. Similar to the pathology residency program, it belongs to the joint venture with three other area hospitals, Illinois Masonic, Mercy Hospital, and St. Francis Hospital of Evanston. This program is set up similarly to the Pathology program. It has an administrative hospital, which is also Illinois Masonic. It operates through a governing body called the surgical joint conference committee (SJCC) which consists of representatives from each of the four participating hospitals. The SJCC determines the educational standards and policies of the program, insures that it meets medical standards of accreditation, selects resident applicants through a National Matching Program, sets terms and conditions of employment for the residents in the program, and provides

certification to residents completing the program. The program is administered by an Executive Director, who is paid by and accountable to the SJCC. The Executive Director's central office is located in the administrative hospital. The Employer does not pay or provide benefits to the residents who rotate through its campus pursuant to this program. Instead, it pays a sum proportional to the time a resident spends on its site to MGH.

In all residency programs indicated above, there are Chief Residents. Chief Residents are typically in their last year of residency, and are selected to serve as Chief Resident because of their excellence in performance. Chief Residents are given administrative duties, such as assisting in the coordination and topic selection of the didactic portions of resident training. Chief Residents also make up the on-call schedules, and coordinate schedules with Chief Residents in other programs. They also typically sit in on program committee meetings, and may cast an equal vote on matters such as promotion of residents. (Committees are typically made up of six persons). Chief residents do not have authority to hire, transfer, suspend, lay off, recall, promote, discharge, reward, discipline, or to adjust employee grievances. Chief Residents may be responsible for watching to ensure that other residents are behaving competently and reporting to the Program Director or some other faculty member if a problem is perceived. Like all other senior residents, they may assist in training less senior residents and provide them with direction pursuant to their greater knowledge. They also are able to sign a resident's procedure card. Chief Residents do assist in the interviewing process of new resident candidates and participate in making a recommendation on the selection of those candidates. For example, they participate with a selection committee and cast a vote that is equal to other members on the committee. The Employer representatives testified that Chief Residents could recommend 2(11) action to a Program Director or some other person with authority to act, such as transfer, suspension and discipline. Thereafter, the Program Director, or other official cloaked with actual authority, makes an independent assessment of any given situation, and determines for themselves how matters should be handled.

The residency programs are administered by Directors and Department Chairs who are typically employed by the Employer. The attending physicians (also known as faculty) in various programs at the Employer's hospital are primarily employed by the Advocate Medical Group (hereinafter, AMG doctors), a separate corporate entity from the Employer. Many of these AMG doctors are also faculty members of the University of Illinois at Chicago or another university. The AMG doctors are employed by, are paid and given benefits though, and sign a contract with, AMG. AMG doctors are typically employed as specialists and the Advocate Medical Group distributes them at practice sites of the Advocate Health and Hospitals Corporation, including both clinics and hospitals. AMG doctors are required to utilize their specialty skills to treat patients at the sites where they are practicing and also engage in additional teaching or administrative duties that may arise. AMG doctors are not necessarily restricted to a single practice site, but do typically have a "primary" practice site. In order to engage in any outside medical practice, the AMG doctors must first obtain permission from the AMG. Their salary is calculated on a formula basis, which computes to substantially higher rates than the

Employer's residents. Other benefits are mostly identical for AMG employees and the Employer's staff, with a few exceptions, such as different health insurance.

AMG has its corporate offices in Des Plaines, Illinois, though they will be relocating to an administrative office portion at the Employer's site. The AMG is an operating division of the AHHC, as is the Employer. Both the AMG and the Employer have their own officers, managers, and supervisors. However, AMG and the Employer do share a common Human Resource Director, Penelope Pilarczyk. Ms. Pilarczyk has dual responsibility, pursuant to this arrangement. On the AMG side, she reports to Deb Geihsler, who is the Chief Executive of AMG. Geihsler reports to Dan Schmidt, who is employed by AHHC. Both Pilarczyk and Geihsler maintain offices at the AMG headquarters located in Des Plaines Illinois, and at the Employer's site. There is no evidence on record to suggest that Ms. Pilarczyk has a substantive role in the determination of the employment status of doctors in the AMG group. The labor employment policies for doctors employed by AMG have been generated primarily by Geihsler, Tom Dedrich, the Vice President of Compensation and Benefits, and the AMG legal department. Ms. Pilarczyk did review the employment policies, however, and helps in their administration. On the Employer side, Ms. Pilarczyk reports to Mr. Rojek, the Employer's Chief Executive. Ms. Pilarczyk testified that she was completely unfamiliar with the bylaws, rules and regulations for the Employer's medical staff. The Employer also asserts in its brief that the AHHC board of directors establishes and approves salaries and benefits of both the AMG and the Employer. However, the record shows no evidence of this, and the Employer had not cited any documents to support that particular assertion.

Analysis

The Employer contests that the PRN is not a labor organization under the Act. Section 9(c)(1)(A) provides that employees may be represented "by any employee or group of employees, or any individual or labor organization." A "labor organization" is defined in the Act in Section 2(5) as follows: "… any organization of any kind, or any agency or employee representation committee or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours of employment, or conditions of work." Further, the organization does not have to be presently engaging in representation activities, as an intention to do so is adequate. See, e.g., *Butler Mfg. Co.*, 167 NLRB 308 (1967); see also *Yale University*, 184 NLRB 860 (1970).

Clearly, the PRN is an organization which admits employees to membership, and its intention is to represent those employees. The Employer contends, however, that Petitioner should be disqualified from representing the Employer's physicians because of speculation that supervisors serve as officials and directors of PRN. However, mere supervisory status is not automatically exclusionary. There must also be a demonstration of a conflict of interest. In *Sierra Vista Hosp., Inc.,* 241 NLRB 631 (1979), the Board recognized that under some circumstances the participation of supervisors in the internal operation of an association that is attempting to represent unit employees may serve to disqualify the association from representing certain employees. Such disqualification will result when an employer meets the "heavy burden" of showing that the participation of its

own supervisors, or supervisors of employers with a demonstrated connection to it, presents a "clear and present danger" of a conflict of interest which compromises the labor organization's bargaining integrity. See, e.g., *Lodi Memorial Hospital Association***,** 249 NLRB 786 (1980).

Nothing contained in the lengthy offer of proof about what the Employer believed the Petitioners Board members would testify to would establish any relevant "clear and present danger" of a conflict of interest. First of all, none of the Employers supervisor's are remotely connected to the Petitioner's Board, and the Board members are not employed by employers with any relevant demonstrated connection to the Employer in this case. Secondly, even if such a situation were present, there is no relevant existing conflict that could be articulated by the Employer. Accordingly, I find that the Petitioner is a labor organization under the Act and is not disqualified from representing employees of the Employer for purposes of collective bargaining.

The next issue contested by the Employer is the employee status of residents. This issue has been previously examined by the Board in detail, in a strikingly similar factual situation. In *Boston Medical Center Corp.*, 330 NLRB No. 30 (1999), the Board ruled that despite the educational aspects of resident programs, residents clearly meet the Act's definition of employee. The Employer argues that the present situation is distinguishable from *Boston Medical* because the employees at issue do not "work" for the Employer. In support of this statement, the Employer states that it views the primary purpose of the programs as educational rather than for patient care, that there is "greater" supervision of residents at Employer's hospital, that Directors testified that little economic benefit results from residents, and that these factors make the stipend provided to the residents by the Employer different from stipends given to residents in *Boston Medical*. The Employer also points to several other differences, such as the fact that the Employer is not in Massachusetts, like the employer in *Boston Medical*, which means state licensing for residents differ. However, none of these "distinguishing" factors have any relevance in the analysis of whether the residents are employees under the Act. The definition of "employee" is extremely broad, and anyone not specifically excluded in the Act who performs services for another and receives consideration for those services is without question an employee. See, *Boston Medical Center Corp.*, 330 NLRB No. 30 at 9. The residents here perform services for an employer, e.g., assisting in patient care, just like the residents in *Boston Medical*. They provide these services in the context of resident programs which meet guidelines set by the American College of Graduate Medical Education (ACGME), as do the residents in *Boston Medical*. They are provided a stipend, from which the Employer withholds state and federal taxes, just like the residents in *Boston Medical*. They are provided with additional benefits such as health care, just as the residents in *Boston Medical*. In short, factors such as geography, purpose, profitability, and degree of supervision do not outweigh the factors that support a finding that the residents are employees under the Act. The residents here clearly meet the criteria for employee status.

The Employer contends that in the event that I find the residents to be employees who may organize, the Chief Residents should be excluded as supervisors under the Act.

Under Section 2(11) of the Act, the term "supervisor" includes: Any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment. The burden of proving supervisory status is on the party alleging that such status exists. *Bennett Industries*, 313 NLRB 1363 (1994); *Northcrest Nursing Home*, 313 NLRB 491, 496 fn. 28 (1993); *Tucson Gas & Electric Company*, 241 NLRB 181 (1979). The Board will refrain from construing supervisory status too broadly because the inevitable consequence of such a construction is to remove individuals from the protection of the Act. *Quadrex Environment Co*., 308 NLRB 101, 102 (1992).

The record clearly demonstrates that the Chief Residents do not have Section 2(11) authority. The Program Directors and Department Heads are the ultimate authority, and even in a situation where a Chief Resident makes a recommendation, the person cloaked with actual authority makes their own individual determination. Chief Residents do participate in the resident selection process, by participation on selection committees. They do not, however, have authority to select persons, and their vote on committee is worth no more than any others. Mere participation in the hiring process, absent evidence of authority to hire, or to effectively recommend hire, is insufficient to establish Section 2(11) supervisory authority. See, e.g., *North Gen. Hosp*., 314 NLRB 14 (1994); *Jerry's United Super*, 289 NLRB 125, 141 (1988).

In terms of evaluation of residents, all senior residents help evaluate other residents, and the attending physicians formally evaluate residents. A program committee determines whether to promote residents to the next step, and a Chief Resident's evaluation and participation is simply another factor in the overall consideration. Participation in evaluations in this regard is not indicative of supervisory status. See, e.g., *Coventry Health Continuum***,** 332 NLRB No. 13 (Sept. 14, 2000).

Further, the function of Chiefs as a whole, e.g., coordination of aspects of the program and assisting in training and evaluations stem from their professional status and experience. When a professional gives directions to other employees, those directions do not make the professional a supervisor merely because the professional used judgment in deciding what instructions to give. *Providence Hospital*, 320 NLRB 717 (1996). Furthermore, it is settled Board law that the authority of an individual employee to direct another to perform discrete tasks stemming from the directing employee's experience, skills, training, or position does not constitute supervisory authority. *McGraw-Hill Broadcasting Co.,* 329 NLRB No. 48 (1999). In these circumstances, such directions simply are incidental to the employees' ability to perform their own work. In sum, the record does not support the Employers assertion that the Chief Residents are supervisors.

Next, the Employer contends that any appropriate unit that includes residents employed in their stand alone programs must also contain residents in the affiliated and joint venture programs, as well as certain AMG doctors. It makes this contention based

on a claim that it is a joint employer with entities involved in the affiliated and joint-venture programs, and either a single or joint employer with AMG.

In terms of the affiliated residency programs, the existence of a joint employer relationship is essentially a factual issue that depends on the control that one employer exercises over the labor relations of another employer. Under current Board precedent, to establish that two or more employers are joint employers, the entities must share or codetermine matters governing essential terms and conditions of employment. *Riverdale Nursing Home*, 317 NLRB 881, 882 (1995). There must be a showing that the employer meaningfully affects matters relating to the employment relationship such as hiring, firing, discipline, supervision, and direction. *Laerco Transportation & Warehouse*, 269 NLRB 324 (1984). For example, a situation where one employer has negotiated successive collective-bargaining agreements with the Union for another employer's employees is indicative of joint employer status. *Executive Cleaning Services*, 315 NLRB 227 (1994).

In each of the affiliated programs with the University of Chicago, University of Illinois, and Loyola University, the Employer has no meaningful effect on the labor relations of the residents. The Employer cannot meaningfully affect the residents' overall schedules, wages and benefits, and cannot select them to, or remove them from the program. While it assigns tasks when residents are on site, this is incidental to the professional function of providing proper medical care. Additionally, while the Employer may send evaluations of residents to an appropriate outside official for the time spent on Employer's campus, this is simply a reporting function. A different employer is the ultimate authority on resident employment, progression, discipline, and ultimate completion in these programs. There is no joint employer relationship in regard to any of the affiliation programs.

In regard to the AMG doctor issue, it is clear that AMG doctors are employed by the AMG, not the Employer. However, the Employer argues that it is a single employer, or at least a joint employer, with AMG. In deciding the single employer question, the Board considers four factors, none of which, alone, is controlling, nor need all be present. The four factors are: (1) interrelation of operations, (2) common management, (3) centralized control of labor relations, and (4) common ownership. See, e.g., *Mercy General Health Partners Amicare Homecare***,** 331 NLRB No. 93, (July 17, 2000); *Dow Chemical Co.,* 326 NLRB 288 (1998). The Board has generally held that the most critical factor is centralized control over labor relations. *Mercy General Health Partners Amicare Homecare***,** 331 NLRB No. 93 (July 17, 2000).

There is no doubt that the entities of AMG and the Employer have common ownership, as both are operating divisions of the AHHC. However, common ownership, while necessary, is not determinative in the absence of centralized control over labor relations. *Western Union*, 224 NLRB 274, 276 (1976). The Board has addressed the common ownership issue in the similar context of parent-subsidiary relationships. In *Dow Chemical*, the Board held that such common ownership, by virtue of a parent-subsidiary

relationship, by itself, indicates only potential control over the subsidiary by the parent entity. The Board concluded that a "single employer relationship will be found only if one of the companies exercises actual or active control over the day-to-day operations or labor relations of the other." *Dow Chemical Co.,* 326 NLRB 288, at 288 (1998). Therefore, the core question is whether either AMG or the Employer exercises actual or active control over the other. There is no evidence to show that AMG has control over the day to day labor operations of the Employer, nor that the Employer has such control over AMG.

Concerning common management, each entity shares a human resources director, who does not appear to be involved in substantive labor relation decisions, but rather exists in an administrative support role for policies that are determined by officials in either organization. Further, though the Employer asserts as such, there is no support in the record for the claim that the parent corporation, the AHHC, controls the formulation of policies, or the day to day labor relations of either entity. Instead, record evidence supports that the Employer and AMG are separate corporate entities who determine their own labor policies and have their own directors, managers and supervisors. As such, there is no support for a finding of joint employer status either, as the record does not contain evidence of co-determination of the labor relations of one entity by the other. While there is no doubt that these entities share common objectives and mutual assistance, this does not command a finding of either single or joint employer status. See, *Wisconsin Education Assn*., 292 NLRB 702 (1989).

A joint employer relationship could be said to exist in the joint venture programs with the MGH. In Pathology, while the designated administrative hospital, Illinois Masonic, administers the labor relations of residents in the program including wages, benefits and ultimate accreditation, such matters are subject to a majority vote by a governing board made up of representatives from each hospital. The Employer also provides one of several practice sites, contributes a lump sum for the time residents are on its premises, and provides appropriate medical direction and supervision to the residents as they rotate though. Because the Board is made up of individual participant representatives who have an equal vote in matters such as resident stipends and benefits, there is co-determination of labor relations indicative of joint employer status. The MGH Surgical Residency Program, is governed in a similar manner. The residents in this program are selected by, hired by, paid by, accredited by, and ultimately answer to the governing board (the SJCC) for the program . The Employer designates a representative to participate on the SJCC with other hospital representatives, and has an equal vote. As such, the evidence appears to suggest co-determination of the labor relations of the employees.

However, determination of joint employer status does not change the analysis of appropriate unit, which is really the crux of the entire matter. It is settled Board law that even if certain affiliated or joint-venture residents, or certain AMG doctors could be included in the unit, this does not mandate that they must be included in the unit. Such considerations are irrelevant if the petitioned-for unit is appropriate. The Board has long held that “there is nothing in the statute which requires that the unit for bargaining be the

only appropriate unit, or the ultimate unit, or the most appropriate; the Act only requires that the unit be "appropriate". *Overnight Transportation Co.*, 322 NLRB 723 (1996). Therefore, the petitioned-for unit need only be an appropriate unit for purposes of collective bargaining, not the most appropriate unit. *Omni International Hotel,* 283 NLRB 475 (1987). The Board's declared policy is to consider only whether the unit requested is an appropriate one, even if it may not be the optimum or most appropriate unit for collective bargaining. *Black & Decker Mfg. Co*., 147 NLRB 825, 828 (1964). The burden is on the employer to show that the petitioned-for bargaining unit is inappropriate; if the unit sought by the petitioning labor organization is appropriate, the inquiry ends. *Audiovox Communications Corp.,* 323 NLRB 647 (1997); *P.F. Dick Contracting Inc.,* 290 NLRB 150, 151 (1988).

The Employer's apparent reliance on *M.B. Sturgis, Inc.,* 331 NLRB No. 173, (Aug. 25, 2000) as an argument for inclusion is misplaced. It is clear that *Sturgis* does not compel inclusion of employees where joint employer status exists. In fact, *Sturgis*, in a reexamination of *Greenhoot, Inc*., 205 NLRB 250 (1973), and *Lee Hospital*, 300 NLRB 947 (1990), simply clarified that community of interest is the appropriate test in unit determinations that may involve multiple employers, and the consent of other employers is not required. Moreover, because the Regional Director in *Sturgis* had not considered the community of interest between jointly employed employees and solely employed employees, that issue was remanded for proper analysis. Accordingly, *Sturgis* did not alter the settled rule that in order to insist on any alternative unit, an employer must first establish that the petitioned-for unit of employees is an inappropriate unit based on the employees' strong community of interests with other employees. See, e.g., *Audiovox Communications Corp.,* 323 NLRB 647 (1997); see also *M.B. Sturgis, Inc.,* 331 NLRB No. 173, slip op. at 9 ("application of our community of interest test may not always result in jointly employed employees being included in units with solely employed employees.").

Based on the testimony and evidence presented at hearing in this case, I find that the Employer has failed to meet its burden of showing that the petitioned-for bargaining unit is inappropriate under the Act without the inclusion of the rotating residents in affiliated or joint venture programs and without inclusion of the AMG doctors. While rotating residents may share some common interests with the petitioned for residents in the short periods of time that they are working at the Employers site, many significant differences exist. Since, as discussed above, the Employer is not a joint employer of residents in the affiliated programs, affiliated program residents do not even have a common employer with the petitioned-for unit, which is a requirement for the commencement of any analysis as to unit inclusion. See, *M.B. Sturgis, Inc.,* 331 NLRB No. 173, slip op. at 8. Further, rotating residents, regardless of program are not hired by, paid by, instructed or supervised by, given benefits through, or accredited solely by the Employer. Residents in these programs also spend significantly less time at the Employer's facility than the petitioned-for residents, and have a majority of their program responsibilities at other institutions. Residents in these programs are distinguished from the petitioned-for residents in other ways as well, such as in uniforms and in certain privileges like moonlighting and laundry. Accordingly, there is not an overwhelming

community of interest such that the unit must include these affiliated and joint venture program residents, regardless of whether joint-employer status may exist.

In regard to the AMG doctors, again the Employer is not a single or joint employer with the AMG, so AMG doctors do not even have a common employer with the petitioned-for unit, which is a requirement for the commencement of any analysis as to unit inclusion. See, *M.B. Sturgis, Inc.,* 331 NLRB No. 173, slip op. at 8. Even ignoring this fact, AMG doctors do not have a community of interest with the petitioned-for unit. AMG doctors are attending and faculty members, and none are residents. They are paid substantially more, and are also paid on a completely different basis than the petitioned-for unit. AMG doctors answer to a different hierarchy, and have their terms and conditions set by a different entity. Their main task is to teach and evaluate the unit members. Their contracts are substantially different from employees in the petitioned-for unit. For example, the AMG contracts have a clause that proclaims the relationship to be that of an independent contractor. The relationship between the Employer and the unit petitioned-for cannot be construed in such a manner. In short, there are significant differences between AMG employed doctors and the petitioned-for employees, such that the community of interest between the two is certainly not strong enough to compel a finding of inappropriateness without the inclusion of the AMG doctors. Additionally, a unit substantially similar to the one in this case has already been found to be appropriate by the Board, and faculty staff analogous to the AMG doctors were not a part of that unit. See *Boston Medical Center Corp.*, 330 NLRB No. 30 (1999). With regard to the Employer's argument that AMG doctors in clinics outside the Employer's hospital should be included, that analysis is not relevant for discussion here in light of the fact that AMG doctors do not have a common employer with the petitioned-unit and beyond this do not have a sufficient community of interest to mandate their inclusion in the unit.

The Employer also argues that there are nine staff physicians who do not fall into the categories of resident, AMG doctor, or supervisory Employer doctor, that should be included in the unit. The Petitioner did not address these nine physicians in its brief, and it is not clear from the record what its position is in regard to these physicians. There is insufficient evidence in regard to these physicians available to make a finding as to their inclusion in the unit. As such, these nine physicians may vote, subject to challenge.

I find that the petitioned-for unit is an appropriate unit for purposes of collective bargaining. There are approximately 170 employees in the unit.

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